

Texas Neurosurgery LLP

3600 Gaston Ave. Ste. 907
Dallas, TX 75246
(214) 823-2052

Patient ID : 67844
First : ROBERT
Last : PLOCK

Credit Card - Sale

--- Approved ---

Response Message : APPROVAL
Response Code : 000

Jul 31 2013 4:27:55 PM

Card Type : MC
Card Holder Name : ROBERT PLOCK
Card # : *****4413

Auth Amount : \$40.00
Auth Code : 436545

I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO MY CARD HOLDER AGREEMENT.

X

(Signature)

Have a nice day.

Texas Neurosurgery, L.L.P.

TYPE OF VISIT:
☒ New Patient ☐ Work Comp ☒ Auto ☐ Other

DEMOGRAPHIC INFORMATION

Name: Plock Robert A DOB: 07/26/1968 AGE: 45 Social Security: 456533292
Last First Middle Initial
Address: 6827 Latta Pkwy Dallas TX 75227
Number Street City State Zip
Cell Phone: 2147997775 Home Phone: 2142754195 EMAIL: robpllock@gmail.com
Who referred you to our office? Dr Christensen Phone Number: 2148285775
Who is your primary care doctor? Dr Christensen Phone Number: 2148285775 Location: Swiss Ave Del
Emergency Contact: Clarence Abner Phone Number: 2147997774 Relationship: Friend

ADDITIONAL INFORMATION

☒ Male ☐ Female Marital Status: ☐ Married ☒ Single ☐ Other: _____

Race: ☒ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other
Ethnicity: ☐ Hispanic ☒ Non-Hispanic/Non-Latino ☐ Other/ Non-determined
Languages Spoken: ☒ English ☐ Spanish ☐ Other: _____

Occupation: _____ Employer: Spencer A/C Address/Phone: 3006 Skyway Cir S. Irving, TX 75038

Does this visit pertain to a workers compensation injury or a personal injury? ☐ No ☒ Yes, If yes, MVC

Date of Injury: 01/25/2013 Claim #: _____ Adjuster Name: _____ Phone Number: _____

Is there a lawsuit planned, relating to your problem or injury, whether it be from a workers compensation claim or motor vehicle accident? ☐ No ☒ Yes

INSURANCE INFORMATION

Primary Insurance: UMR Subscriber ID # 13280912 Group # 76-410892
Primary Card Holder: ☒ Self or ☐ Spouse ☐ Parent ☐ Other: _____

CoPay: \$ 40⁰⁰ SELF /
LAB: _____ Name Of Policy Holder Date of Birth of Policy Holder

Secondary Insurance: _____ Subscriber ID # _____ Group # _____
Secondary Card Holder: ☐ Self or ☐ Spouse ☐ Parent ☐ Other: _____

Name Of Policy Holder Date of Birth of Policy Holder

Besides regular mail, I authorize Texas Neurosurgery to contact me by the following methods: (please check boxes)

☒ cell phone ☐ text messaging ☒ home phone ☒ Email
DATE: 07/31/2013 SIGN: 1. Robert Plock

PATIENT NAME:

Robert Plock

DATE:

07/31/2013

RELEASE OF INFORMATION TO OTHERS (HIPPA)

I acknowledge that I have received a copy of "Notice of Privacy Practices". I authorize Texas Neurosurgery, L.L.P. and its staff to use and disclose the protected health information described below, to the individuals named. These individuals may also pick up prescriptions, medical records and other health related items on my behalf.

What level of information can we release?

☒ All information including specific medications and dosages, lab results and information related to sensitive issues such as sexually transmitted diseases (including but not limited to AIDS and Hepatitis C).

☐ No information whatsoever

To whom can we release information (please list names):

☐ Clarence Abner Friend
Name Phone# Relationship to Patient
214 799 7775

☐ _____
Name Phone# Relationship to Patient

☐ No one except the patient can obtain information.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing that the revocation will not apply to information already released in response to this authorization.

2.

Robert Plock

Signature of Patient/Guardian

07/31/2013

Date

TREATMENT CONSENT AND AUTHORIZATION

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment and is a means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill and a means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I hereby authorize Texas Neurosurgery, L.L.P. to furnish to any designated attorney or insurance Company all information necessary to file a health insurance claim form, or to obtain reimbursement. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plans to Texas Neurosurgery, L.L.P.

I understand that I am financially responsible for all charges whether paid or not paid by my insurance company. Also, I hereby authorize the disclosure of health information in any data format regarding my treatment during hospitalization and/or outpatient care to Texas Neurosurgery, L.L.P. I understand that this facility will maintain medical records in accordance with state requirements. By my signature below, you are fully authorized to disclose such information when requested by Texas Neurosurgery, L.L.P.

The foregoing information is true and correct to the best of my knowledge. I authorize Texas Neurosurgery, L.L.P. to provide medical treatment to me in the office or in the hospital.

3.

Robert Plock

Signature of Patient/Guardian

07/31/2013

Date

FINANCIAL AND GENERAL POLICY SIGNATURE

I have read and understand the Texas Neurosurgery Financial and General Office Policies. My signature indicates compliance and understanding of these policies and that I have completed all the forms to the best of my knowledge.

4.

Robert Plock

Signature of Patient/Guardian

07/31/2013

Date

Texas Neurosurgery, L.L.P.

PATIENT NAME:

Robert P Lock

DATE:

07/31/2013

PHYSICIAN ASSISTANT CONSENT FOR TREATMENT FORM

Texas Neurosurgery has several Physician Assistants to assist in the delivery of medical care.

A Physician Assistant is not a doctor. A Physician Assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and responsibility for the medical services provided.

MEDICAL SERVICES PROVIDED BY THE PHYSICIAN ASSISTANT

A Physician Assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and /or performing diagnostic and therapeutic procedures.
- Formulation of a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- *Assisting* at surgery
- Offering counseling and education
- Writing prescriptions (where allowed by law)
- Making appropriate referrals.

I have read the above and hereby consent to the services of a physician assistant for my health care needs.

I understand that their services are directed by the physician.

I understand that at any time I can refuse to see the physician assistant and request to see a physician

5.

Robert P Lock

Signature of Patient/Guardian

07/31/2013

Date

PATIENT NAME:

Robert Pluck

DATE:

07/31/2013

REASON FOR VISIT

PLEASE TELL US THE REASON FOR YOUR VISIT:

A Second opinion for the treatment and surgery to correct my back problem

PHARMACY INFORMATION

PREFERRED PHARMACY:

Walgreens

PHONE #:

2143884951

PHARMACY ADDRESS:

4702 N. Tim Miller, Dallas, TX 75227

MEDICATION ALLERGIES

☒ No Known Drug Allergies☒ No Other Allergies (latex, contrast or adhesives..)☐ Yes I have known Drug Allergies (Please list name and symptoms)

1. _____

2. _____

☐ Yes I have Other Allergies to things like latex, contrast or adhesives (Please list name and symptoms)

1. _____

2. _____

CURRENT MEDICATIONS

LIST ALL THE CURRENT MEDICATIONS YOU ARE TAKING

NAME:

DOSE

FREQUENCY

REASON PRESCRIBED:

Example: Benadryl

40 mg

one tab a day

Allergies

1. Hydrocodone/Norco 5-325 4/day pain2. Tramadol 50 6/day pain3. Flexeril 10 3/day spasms4. Ibuprofen 800 3/day pain

5. _____

6. _____

7. _____

8. _____

I understand that prescription refills should be handled at the time of the office visit whenever possible. It is my responsibility to know when my prescription is about to run out. A good rule of thumb is to always have at least a three day supply on hand. Medication refills are only handled during regular business hours and will not be addressed after business hours or on weekends.

PATIENT NAME:

Robert P. Lock

DATE:

07/31/2013

REVIEW OF SYSTEMS AND PAST FAMILY SOCIAL HISTORY

ROS. Does the patient currently have any of these issues? Please circle yes or no

| | | | | | | | | | |
|------------------|-----------------|----|-----|-------------------|----|-----|-------------------------|----|-----|
| Constitutional | Fatigue | No | Yes | Fever/Chills | No | Yes | Weight Loss/Gain | No | Yes |
| | Seizures | No | Yes | Dizziness/Vertigo | No | Yes | Headaches | No | Yes |
| Neurologic | | | | | | | | | |
| | | | | | | | | | |
| Musculoskeletal | Joint Pain | No | Yes | Back/Neck Pain | No | Yes | Morning Stiffness | No | Yes |
| Skin | Rash | No | Yes | Ulcers/Lesions | No | Yes | | | |
| Pulmonary | Short of Breath | No | Yes | Wheezing | No | Yes | Cough | No | Yes |
| Cardiology | | | | | | | | | |
| | Chest Pain | No | Yes | Palpitations | No | Yes | Irregular Heart Beat | No | Yes |
| | Swelling | No | Yes | | | | | | |
| Gastrointestinal | Diarrhea | No | Yes | Nausea/Vomiting | No | Yes | Abd Pain/Blood in Stool | No | Yes |
| Genitourinary | Freq Urine | No | Yes | Pain Urinating | No | Yes | Burning with Urination | No | Yes |
| Eyes/Ears/Nose | Nasal Drainage | No | Yes | Change of Vision | No | Yes | Loss Of Hearing | No | Yes |
| Mouth and Throat | Sore Throat | No | Yes | Tooth Ache | No | Yes | | No | Yes |
| Hematologic | Easy Bleeding | No | Yes | Easy Bruising | No | Yes | | | |
| Psychiatric | Anxiety | No | Yes | Depression | No | Yes | | | |

If you checked yes to any of the above, are you under treatment for this issue with a physician? No Yes

If so, who is the physician treating you?

PFSH: Has the patient or family member ever been diagnosed with any of the following medical conditions?

| | FAMILY MEMBERS | PATIENT | IF YES FOR PATIENT, PLEASE COMMENT |
|---------------------------------|----------------|---------|------------------------------------|
| Heart Disease (CAD) | No Yes | No Yes | |
| High Blood Pressure | | No Yes | |
| Stroke | No Yes | No Yes | |
| Breast Cancer | No Yes | No Yes | |
| Prostate Cancer | No Yes | No Yes | |
| Colon Cancer | No Yes | No Yes | |
| Other Cancer | | No Yes | |
| Coagulation Defects | No Yes | No Yes | |
| DVT (Blood Clots) | No Yes | No Yes | |
| Anemia | | No Yes | |
| Hepatitis | | No Yes | |
| Diabetes | No Yes | No Yes | |
| Kidney Disease | | No Yes | |
| Lung Disease or Asthma | | No Yes | |
| Sleep Apnea | | No Yes | |
| Stomach Ulcers | | No Yes | |
| Colitis | | No Yes | |
| Rheumatoid /Osteoarthritis | | No Yes | |
| Lupus | | No Yes | |
| Epilepsy or History of Seizures | | No Yes | |
| Depression /Anxiety Disorders | | No Yes | |
| Other Health Issues: | | No Yes | |

slight / no pap machine

If you checked yes to any of the above, are you under treatment for this issue with a physician? No Yes

PATIENT NAME:

Robert Plock

DATE:

07/31/2013

PRIOR SURGERIES

Please list any surgeries you have had in the past 5 years

- ☒ Hernia Repair
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

PRIOR HOSPITALIZATIONS

Please list any hospitalizations you have had this past year

- ☒ N/A
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

FAMILY AND SOCIAL HISTORY

☒ Right Handed ☐ Left Handed

☐ Height 5' 11" ☐ Weight 200^{lb}

Alcohol Intake: Please circle the one that applies to you: Never Drink Drink Socially Drink Daily:
wine beer liquor

Do any Family Members Have an Alcohol History? ☐ Yes ☐ No

Smoking History: Have you ever smoked? ☒ Yes ☐ No If yes, How long? 10 yrs How Many 1/2 packs/day
Have you quit smoking? ☒ Yes ☐ No If yes, When? 1990 How Many _____ packs/day

Blood Products/Transfusions:

Do you have any objections to receiving blood or blood products? ☒ No ☐ Yes

OTHER HEALTH RELATED ISSUES NOT COVERED ABOVE

PHYSICIAN ONLY

I have reviewed the listed ROS/PFSH/Screening with the patient and noted the positive/negative findings for this visit.

SIGNATURE OF MD: _____ DATE: _____

Daily Service Timecard

Employee Name: _____

Date: _____

Employee Number: _____

Day: SU M T W TH F S

(Circle One)

[illegible]

| | |
|-------------------------------|------------------------|
| 01 Billed Service Call | 07 Meeting |
| 02 Install - Warranty | 08 Maintenance |
| 03 Job Work For Install | 09 Working For Install |
| 04 Own Service Call Back | 10 Training |
| 05 Other Service Call Back | 11 Misc. Projects |
| 06 Unapplied Time <i>Shop</i> | 12 Vacation & Holiday |

Totals# of Trips
Traveled

Number of Billable Service Tickets

Signature _____

did not have a physical injury today.

Manager Approval _____

My vehicle & contents inside were not damaged today.

UMR-M-F 7A-5P Central

June - 24-28 - 65° - 1 wk

July - 4 wks - 260⁰⁰ / 395⁰⁰
August - 140⁰⁰
2 wks + reg fee

AMY
Barnett
Baylor
#907
~~8:30 AM~~ Wed 3/15
3:00 PM
Written
report of
Mr. I
Dr. Michael
214 823 37917
+ X Neurosurgery
LLP.com
New patient
forms